CARE FOR THE ELDERLY

Developing A More Co-ordinated And Community-based Approach

Ontario

DISCUSSION PAPER

PROGRESSIVE CONSERVATIVE CAUCUS OF ONTARIO

CARE FOR THE ELDERLY

Developing A More Co-ordinated And Community-based Approach

Ontario

A Discussion Paper By
The Grossman Task Force On Human and Social Services
Progressive Conservative Caucus Of Ontario

April 1986

Available by mail from

Office of the Official Opposition Leader
Parliament Buildings
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FORWARD

Ontario Progressive Conservative Party Leader Larry Grossman appointed the Human and Social Services Task Force to enquire into a broad range of services in the health and social services fields; to produce discussion papers; and to consult with concerned groups on all aspects of human services.

Based on the input from special interest groups, experts and the general public, each discussion paper will be refined and expanded to become the official policy of the Ontario Progressive Conservative Party.

CARE FOR THE ELDERLY: Developing A More Co-ordinated And Community-based Approach, is our Task Force's first discussion paper and is intended to be the starting point in that consultative process.

We are very proud of the system and network of health and social services that we developed here in Ontario, but we believe it is now time to move that system forward, to improve upon it, and to modernize it so that it responds sensitively and efficiently to the needs of future generations.

The Ontario Progressive Conservative Caucus welcomes critical comments and constructive suggestions from all concerned groups on this and future discussion papers.

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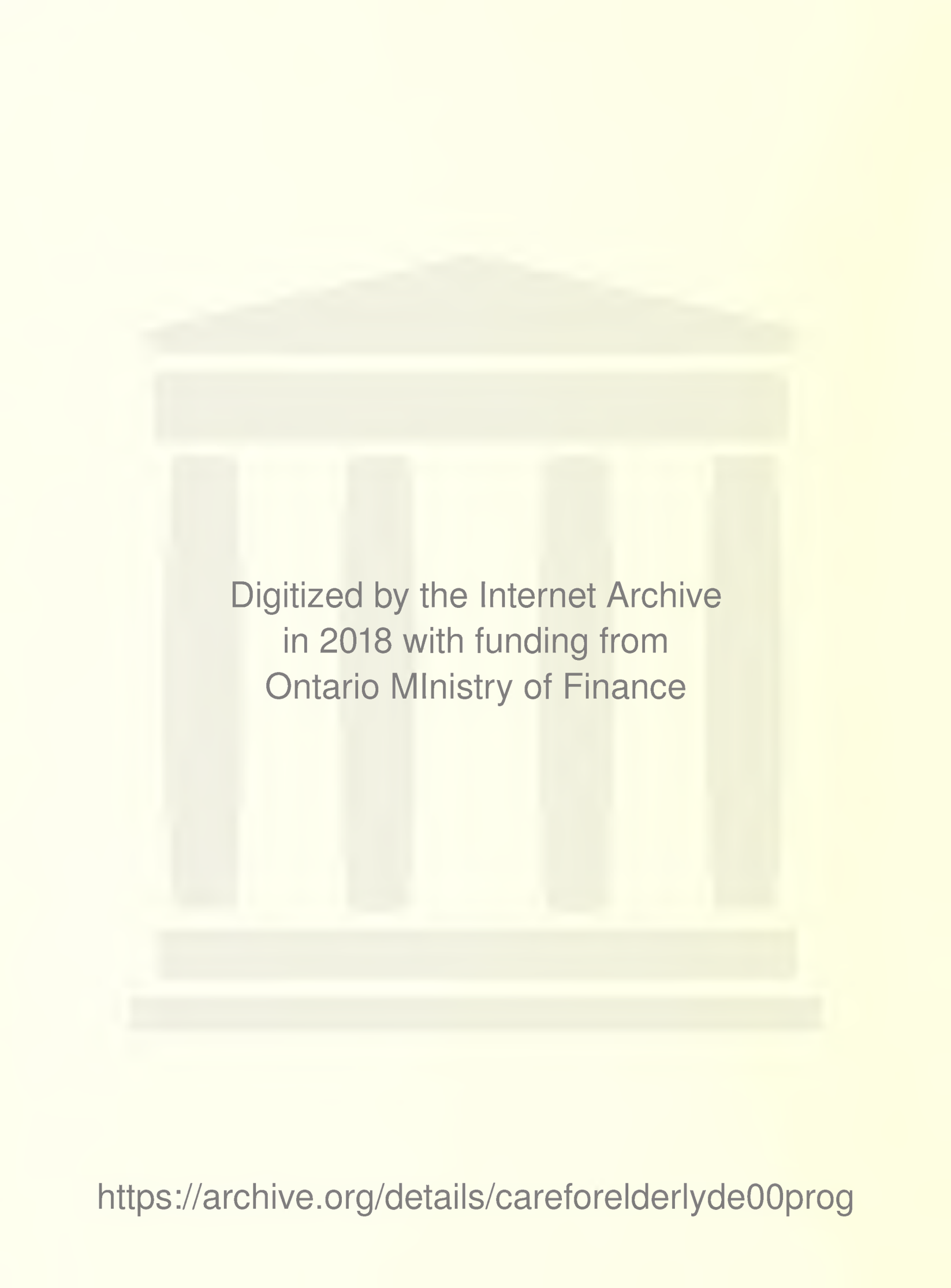

EXECUTIVE SUMMARY

This discussion paper argues that there is a critical and urgent need to develop a more co-ordinated and community-based approach to care for the elderly.

It points out that Ontario will experience a 55 percent increase in the number of senior citizens over the next 15 years and that if we maintain our current pattern of institutionalizing our elderly, it will cost an additional $6 billion to build and operate new facilities.

The report argues that if we were to shift the existing system of care for the elderly away from its institutional orientation then we could re-deploy the money saved into building a vastly expanded and improved network of community-based services and senior citizens housing.

These new and expanded services and programs, including home care, homemakers services, nursing care, respite care, meals on wheels and handyman programs, should be co-ordinated at the local level by Placement Co-ordinating Agencies and linked to the extended care system.

In addition to co-ordinating home support services in their local communities, these Placement Co-ordinating Agencies would provide professional geriatric assessment services and case-management to ensure that seniors obtain the appropriate services according to their changing needs.

The report also argues that the entire extended care system of nursing homes, homes for the aged, retirement homes and rest homes should be rationalized, co-ordinated and linked to the community-based services so that seniors can have a continuum of care services.

The primary emphasis throughout **CARE FOR THE ELDERLY: Developing A More Co-ordinated and Community-based Approach** is on programs and services that would enable seniors to live independent, dignified lives.

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Chapter I

OVERVIEW

For years we have talked about the growing proportion of our population living beyond 65 years of age.

We now have at hand considerable information on:

- demographic shifts in our population;
- new service requirements for senior citizens;
- a need for budgetary re-allocations; and
- a need for more beds and buildings.

Inundated as we are by the incredible amounts of research and data on aging, we in the Ontario Progressive Conservative Caucus are not convinced that our society has really looked on this issue as much more than a challenge best left for government to find the money to build more nursing homes and chronic care beds.

But the fact is: we already have one of the highest rates of institutionalization of the elderly in the world.

Our caucus believes it is time that we, as a society, start to look -- realistically and sensitively -- at the nature and implications of the demographic changes taking place in this province.

It might help if we begin by understanding the obvious: people don't turn 65 and suddenly become heavy users of the health care system. They don't automatically become sick and dependent because they are "old". In fact, more than half of the senior citizens in Ontario who reach the age of 85 are still active in the community.

So the question we should be asking ourselves is: how can we make it possible for the greatest proportion of our elderly to remain healthy, independent -- in the community -- and functioning usefully?

Surely we must focus on a balanced and rational understanding of the realities of aging, and on the needs of the aged. We must focus -- not just on caring for the ill -- but on promoting and maintaining the health of the elderly in our society.

Most importantly, we believe that we must focus on the best means of ensuring that the greatest proportion of our aged remain independent, productive, and contributing members of their communities and our society.

Working toward these goals will involve many elements -- all of which could, and should, combine effectively together.

Some of the elements that we think should be included in a co-ordinated long-term strategy for the aged include:

- the role of the family unit;
- the provision of adequate income support;
- options to provide supportive housing for the elderly;
- the development of a vastly expanded network of community-based support services for the elderly; and
- a more appropriate role for nursing homes, homes for the aged, and chronic and acute care hospital beds.

While it is true that we already have developed many of the major components of a system to care for our elderly, the fact is that our existing system could soon be inadequate to meet the challenge of our future demographic realities if we don't reform and improve upon it.

HALF A MILLION MORE ELDERLY

Between now and the year 2001, Ontario's senior citizen population will increase by over half a million people -- a 55 percent increase. The majority of that growth will take place within the next decade.

ONTARIO DEMOGRAPHIC PROJECTIONS, 1983-2001
(IN 000's)

Age Group	1983	2001	Change	%Change
0-14	1,871	1,734	-138	-7.4%
15-44	4,247	4,410	+163	+3.9%
45-64	1,787	2,472	+685	+38.3%
65+	**913**	**1,419**	**+507**	**+55.5%**
All Ages	**8,818**	**10,036**	**+1,217**	**+13.8%**

So, while our overall population will grow by just under 14 percent, there will be massive growth in the proportion of our population who are senior citizens.

In designing a co-ordinated system of care for the elderly, we must understand that the absolute demographic numbers do not tell the whole story.

Demographers usually sub-divide the elderly into three basic categories: the "young" elderly, (age 65-74); the "middle" elderly, (age 75-84); and the "old" elderly (age 85+).

In designing a new and enhanced system of care for the elderly, it is important that we understand the basic needs of each of these groups.

For example, the **"Young" Elderly** -- in the 65 to 74 year old age bracket -- are normally very independent and active. However, some in this category may have at least one chronic condition and a small proportion may require some form of assistance in daily living.

The **"Middle" Elderly** -- in the 75 to 84 year old age bracket -- have another set of problems. Many experience difficulties with the basic requirements of daily living due to multiple chronic conditions, and many require increasing levels of support and assistance.

Finally, the **"Old" Elderly** -- who are over 85 years of age -- face the most severe problems. They face increasing levels of ill health, disability, depression and, in some cases,

mental frailty. Also, it is important to remember that about 75 percent of the "old" elderly are women who have lost their spouse and are on their own.

It is important that the special conditions affecting all three of these groups be taken into account in the design of a co-ordinated system of care.

Between now and the year 2001, we will see a 138 percent increase in the number of "old" elderly; a 68 percent increase in our "middle" elderly; and a 37 percent increase in our "young" elderly population.

Since the average life expectancy of Ontarians is increasing, we must design a comprehensive and properly co-ordinated system that takes into account all of these demographic factors. In particular, we must prepare and design systems that enable our "young" and "middle" elderly to be independent for as long as possible, while also designing flexible systems to accommodate the needs of an increasing "old" elderly population.

PROJECTIONS ON LONGEVITY 1983-2001

Age Group	1983	2001	Increase	% Increase
65-74	553,610	757,302	203,692	37%
75-84	276,020	463,878	187,858	68%
85+	**83,140**	**198,198**	**115,058**	**138%**
All 65+	**912,770**	**1,419,378**	**506,608**	**55.5%**

TODAY'S $4 BILLION PROGRAM

The challenge facing our society today is to respond to these basic demographic realities with programs and services that are co-ordinated and designed to give our senior citizens the maximum degree of independence and dignity.

Over the past two decades, the Ontario Progressive Conservative Government built an infrastructure to assist those elderly living in long term care facilities and, to some extent, those living in the community. We also developed programs for income support, general and chronic health care services and social support programs and services for seniors.

These programs are operated by the Ministries of Municipal Affairs, Housing, Revenue, Health, and Community and Social Services. Collectively they constitute a net value of about $4 billion a year in assistance to our senior citizens.

This $4 billion commitment is broken down in the following ways:

In the area of **income support programs**, annual expenditures amount to over $1.1 billion. This includes $360 million on the OHIP premium waiver; $347 million on sales and property tax grants; $278 million on the Drug Benefits Program for senior citizens; $112 on GAINS; and an additional $54 million on assisted rental housing programs for seniors.

In the **health care services** field -- including general hospital services and OHIP -- seniors account for a further $2 billion in expenditures.

Long term care services in municipal Homes for the Aged, Nursing Homes, Charitable Homes for the Aged and chronic care hospital services account for an additional $800 million in annual expenditures.

However, on **community-based services** for seniors -- including home care, homemakers and nursing services, home support services, and elderly persons centres -- the province currently spends a modest $85 million a year.

Taken together, these programs constitute an impressive array of services. However, if one considers the demographic realities of the next two decades, the current expenditure level of $4 billion will be totally inadequate to meet the needs of our emerging elderly population -- particularly in our health care system.

Today, 10 percent of our population or 900,000 residents are over 65 years of age. However, this segment of our society accounts for fully 36 percent of our total expenditures on health care services.

In fact, seniors represent about:

- 20 percent of our total OHIP payments;
- 40 percent of days of general hospital care;
- 79 percent of days of in-patient chronic care; and
- 93 percent of extended care in nursing homes.

This is obviously a significant demand on the province's health care system. And when we consider that between now and the turn of this century our population of senior citizens will increase by 55 percent, we can understand how health care issues related to aging represent the single biggest concern now facing our health care system -- and to our total expenditures on the elderly.

The critical policy decision facing Ontarians in the future is: will we respond to the growing number of elderly by simply expanding the number of hospital and nursing home beds? Or will we develop new and more positive options that will help a larger portion of senior citizens remain healthy and contributing members of our society?

SHIFTING RESOURCES TO THE COMMUNITY

As we plan the development of future directions of service we must begin by examining our attitudes about aging and the aged. Frankly, we are concerned that too many of us still tend to equate "aging" with "illness".

Aging, in fact, is a natural process which does not -- and should not -- inevitably lead to hospitalization and dependency. More than half the senior citizens who reach the age of 85-90 in this province are still active in their own communities.

Nevertheless, the traditional stereotypes can, at times, condition us to accept institutionalization as the "automatic" response to growing old. The problem is: the more deeply such attitudes take root, the less likely will we be to seek ways of preserving the independence and good health of our elderly.

The most important component of any long-term strategy for the aged must take into account the requirements of senior citizens themselves -- and their families.

Most families acknowledge their responsibility -- not grudgingly, but freely and affectionately -- to play a key role in helping their aging relatives remain active, vigorous, and independent.

But while we, as a society, are deeply committed to the concept of dignity and security for the elderly, we are not convinced that we have succeeded in strengthening and re-enforcing that value within the family unit.

In fact, in our efforts to provide the highest standards -- to the greatest number of people -- some of our existing programs for the aged may have inadvertently encouraged families to abrogate their responsibilities and shift the onus to government.

Perhaps we should be looking at more systems of support -- or incentives -- to help families deal with the practical difficulties involved in caring for the aged, and in so doing, lessen our overall dependence on institutional care.

Perhaps, for example, government taxation mechanisms could be used more effectively to assist those who want to renovate or expand their homes to accommodate an elderly parent. Or, perhaps direct assistance could be offered to families who are willing to make adjustments to their lifestyles so they can keep an aging relative at home.

We should consider how society can work to reinforce important values so that more families will be able to care for their relatives if they so choose. In addition to the choice of the family, a sensitive and effective response must involve a focus on community-based health support services which have as their objective the continued health and independence of the elderly.

While serving as Treasurer of Ontario, Larry Grossman introduced a program that enabled families to make tax exempt improvements and additions to their homes so they could accommodate elderly family members.

This program proved to be a good start. But are there additional incentives that government can provide so our seniors can continue to live independent dignified lives in their own communities -- with their own family and friends?

The Progressive Conservative Government introduced a number of programs delivering health-related care to people in their

homes. For example, home care programs were established across the province, and chronic care programs are now operating in 38 Ontario communities through 81 local offices.

There are, as well, a variety of excellent social programs sponsored by the Ministry of Community and Social Services.

The problem, however, is this: Ministry of Health services were designed primarily to respond to health needs, while COMSOC programs were designed primarily to respond to social needs and poverty.

But the needs of the elderly often transcend these two limited areas. We believe that it is now critically important to alter the focus of these existing services and to develop programs and policies that support the independence of the elderly in their own communities.

In our view, this can be accomplished through a massive expansion in our community-based services to the elderly, through improved housing programs and through better co-ordination of health and social services -- at the community level.

Chapter II

SHIFTING THE SYSTEM

There is now a critical need to rapidly shift the direction and level of expenditures on many of our existing support programs for the elderly.

We believe that the shift should be away from the institutional model to one that promotes locally-run community-based support services, income support programs, and supportive housing for our senior citizens.

If we were to project the same patterns of institutionalization that exist today to the year 2001 -- when we will have half a million more senior citizens -- the increased cost to the health care system alone would be almost $6 billion.

This would include over $3 billion in capital costs to construct 14,000 acute care beds; 7,000 additional chronic care beds; over 2,000 psychiatric beds; 1,000 additional rehabilitation beds; and approximately 34,000 additional extended care beds.

On the operating cost side, direct expenditures in the health care system would increase by almost 40 percent -- and add at least an additional $3 billion to our annual health care bill.

In other words -- excluding income support housing and community-based programs -- we are looking at a $6 billion expenditure increase on senior citizens by the year 2001 -- if we simply maintain our existing institutional orientation.

But would we be improving the quality of life for our senior citizens?

Furthermore, we believe that it is time to plan for a fundamental shift in our existing health and social service system.

In contrast to this high-cost institutional health care orientation, we are currently only spending about $68 million on social services and housing assistance that enable senior citizens to remain on their own, in their own communities.

SOCIAL AND HOUSING EXPENDITURES ON THE ELDERLY

Housing Assistance	$ 54 M
Homemakers and Nursing Services	7 M
Home Support Programs	5 M
Elderly Persons Centres	2 M
TOTAL	$ 68 M

Obviously, from now on, government should target the bulk of its new resources on those services that promote the independence of our senior citizens.

Our Task Force believes that if we continue to put our elderly in institutions at the rate we do now, not only will the costs be prohibitive, but we will also perpetuate what the **CMA Task Force on the Allocation of Health Care Resources** called "the callous practice of warehousing the elderly".

Attitudes toward the elderly must change to promotion of health and well-being. As the CMA Task Force said in their report:

> **"Even if it becomes necessary for an old person to enter a nursing home or home for the aged, why should we assume that that person will remain there for life? Surely the aim should be to rehabilitate and rejuvenate so that as many old people as possible could re-enter the community at large -- with the provision of suitable community services this should be possible."**

The fact is that Canada and Ontario currently have one of the highest rates of institutionalization of elderly persons in the world. Almost 10 percent of our elderly are now placed in institutions.

COMPARATIVE INSTITUTIONALIZATION OF ELDERLY

Canada	**9.45%**
United Kingdom	5.00%
United States	5.30%
Australia	5.90%

If we were to reduce our rate of institutionalization -- from the current 9.45 percent to about 5, or even 5.5 percent -- the hundreds of millions of dollars in savings achieved could be reinvested into improved income support programs, assisted housing and more community-based support services for the elderly.

Ontario, therefore, has a clear choice: we can spend a further $6 billion on expanding our institutional system or we can begin now to make major investments in home support programs and housing assistance for our elderly.

INAPPROPRIATE PLACEMENT

The major problems with our existing institutional sector are: the lack of appropriate co-ordination, and the absence of any linkage to the existing -- and underdeveloped -- community-based care system.

This structural problem often results in the inappropriate placement of patients throughout the system.

For example, over 40 percent of all **acute care beds** -- where the orientation is diagnosis, cure and rapid turnover -- are currently occupied by seniors. The Ministry of Health has estimated that about 15 percent of these -- or about 5,000

acute care beds -- are "blocked" by patients who cannot be discharged to more appropriate levels of care.

Since the average cost of an acute care bed is $252 per day; on any given day, that means the total cost of "inappropriate placement" is about $1.3 million -- or over $475 million a year.

This same problem exists in our chronic care system as well.

Chronic care is provided for people who are chronically ill or have a physical or mental disability requiring a range of therapeutic, medical and skilled nursing care. The Ministry of Health estimates that of the 10,840 chronic care beds in Ontario, about 3,600 are "blocked" by patients who are "inappropriately" placed in chronic care facilities.

Since the average per diem cost of a chronic care bed is about $121, everyday almost half a million dollars is spent because "no alternatives" were available.

That's almost $160 million a year.

If **nursing home beds** were the "appropriate alternative" -- and available -- the cost would only be $47.00 per day, rather than the $121 per day for a chronic care bed or $252 for an acute care bed.

But even the nursing home system places the wrong people in the wrong facility.

Both the Ministry of Health and the Ministry of Community and Social Services acknowledge that at least 12,000 extended care beds in Nursing Homes and Homes for the Aged are occupied by persons who require <u>less</u> than the 1.5 hours of nursing care that is required to be "eligible" for admission to these facilities.

That means, a further $600,000 is spent each day -- or $220 million a year -- on "inappropriately placed" patients in extended care facilities.

Let's put this into perspective.

On community-based alternatives, the Ministry of Health spends $73 million on home care services and the Ministry of Community and Social Services spends only $5 million on home support programs and a further $7 million on homemakers and nurses services for the elderly.

In other words, while government is spending $855 million annually on patients who are "inappropriately placed" in our institutions -- because of a lack of alternatives -- they are spending only $85 million on those health and social service community support alternatives.

If there were an adequate home care network, not only would the cost would be much lower, but the services would also be much more appropriate.

Given the fact there is significant "wastage" in the existing institutional system, and given the fact that between now and the year 2001 we would have to invest an additional $6 billion simply to maintain our current patterns, we believe there is an urgent and compelling need to rapidly expand programs and services that provide alternatives to institutional care.

THE NEED FOR CO-ORDINATION

Our Task Force believes that while the system that has evolved in Ontario has served us well over the years, it is now time to begin developing better linkages between the component parts of the system.

That is, we must address the issue of organizing and streamlining our entire range of services. Neither the elderly nor providers of care should have to become experts at navigating through the maze of federal, provincial, municipal and voluntary agency programs.

So, in addition to expanding community support services, we are going to have to find better ways of co-ordinating these services.

Placement Co-ordinating Services for the elderly have been established but only ten are currently in operation throughout the province.

Our Task Force believes that local Placement Co-ordinating Services -- or a similar vehicle -- should become the hub of the health and social system through which the public has access to the various components of the system.

We believe that we should expand and develop our network of local Placement Co-ordinating Services, with certain goals and guidelines in mind.

First, they should be community-based -- preferably centred around a hospital or other major source of health expertise.

Second, they should be operated in the community, by the community.

Third, they should provide comprehensive services simplifying the confusion created by the myriad of health agencies, income support agencies, counselling agencies and housing agencies.

And fourth, they should be universal. No one should be denied service because he or she lives across a regional boundary. And no one should be sent in the opposite direction from friends because he or she lives two blocks away.

If the current government agrees to choose this route -- if they agree to expand and re-orient local Placement Co-ordinating Services -- they will face a number of obstacles.

They will face structural problems -- with vertical Ministry organizations, and often rigid municipal organizations -- that respond to their own administrative systems rather than to people's needs.

Attempts to co-ordinate health and social services from Queen's Park have never really worked in the past -- and there is no reason to believe that they will now. While the current government has created the position of a "Minister Responsible for the Elderly", we do not yet have any <u>real</u> co-ordination of health and social services for senior citizens.

Our Task Force believes that we should be moving toward combined social and health service delivery mechanisms at the <u>local</u> level. In that way, real co-ordination of services can be accomplished in a meaningful way to the citizens we are trying to serve.

Chapter III

CO-ORDINATION OF COMMUNITY-BASED CARE

The community-based care programs that the Progressive Conservative Government established were intended to serve two important functions:

- to enable the elderly to remain in their homes and in their communities so that they may live independent and fulfilling lives; and

- to provide front-line alternatives to the unnecessary institutionalization of the elderly.

However, the problems relating to our existing community-based system are three-fold: they are underdeveloped, underfunded, and un-coordinated.

Community-based programs in Ontario are operated by three main groups: the voluntary sector; the Ministry of Community and Social Services; and by the Ministry of Health.

The largest program -- the **Home Care Program** -- is operated by the Ontario Ministry of Health. It is the only universal community program available to senior citizens on a province-wide basis.

This program is an insured OHIP benefit that has been phased in and improved upon over the past several years and now provides service to over 100,000 senior citizens annually at a cost of about $73 million a year.

We believe that the home care program has done an excellent job of preventing -- or at least delaying -- admissions to institutional settings and has also enabled thousands of elderly patients to be discharged earlier from hospitals. We are proud of that accomplishment.

However, for the past couple of years senior citizens groups, community workers, professional nurses and the general public have pointed out that there are a number of important deficiencies in the Home Care Program.

They have pointed out that since the home care program is available only to people who have a demonstrated health care need -- authorized by a physician -- a great number of people are simply dropped from the program once they are "better". They have also pointed out that the existing system fails to recognize that many of the people "dropped" -- or not even admitted to the program -- still require some form of limited assistance, such as day care or homemaker services.

Because of a lack of relatively low-cost community-based services, a number of people end up being admitted to acute care beds at $252 per day, or to chronic care facilities at an average cost of $121 per day.

But Ministry of Health programs are not the only ones that encourage this type of "inappropriate placement".

Community workers also tell us about the deficiencies that exist within the **Homemakers and Nurses Services Program** sponsored by the Ministry of Community and Social Services.

Those who do not qualify for the Ministry of Health's Home Care Program could qualify for COMSOC's program -- provided that they are "means tested" and agree to pay a limited user fee. However, this program is administered by local municipalities and is managed so that each jurisdiction can set its own local criteria for eligibility -- as well as standards and levels of service.

With limited provincial funding -- currently at only $7 million annually -- the Homemakers and Nurses Services Programs are both inconsistent and inadequate.

The primary problem is that these programs are based on "social" needs and do not take into account the fact that without this kind of service, many "ineligible" candidates simply end up in high-cost inappropriate institutions in the health care system.

Obviously then, there is a critical need to rationalize the Ministry of Health's Home Care Program and the Ministry of Community and Social Service's Homemaker and Nurses Services Programs. We believe that the rationalization of these

programs must be based on one and only one criterion : how can we prevent the unnecessary institutionalization of the elderly?

If that is to be the ultimate goal of these programs, then they must be expanded, co-ordinated and adequately funded to meet the needs of those elderly who can remain at home if they have proper support.

That must involve closer co-operation and co-ordination of these programs, and it must also involve vastly increasing the funding for these types of support programs.

THE VOLUNTARY SECTOR

There are a number of voluntary and private sector community services that can offer some of the necessary support services so that our senior citizens remain in their homes -- with dignity, and an enhanced quality of life.

For example, the **Meals on Wheels Program** can and should become an important part of our efforts to accommodate those senior citizens who wish to remain in their own homes.

Many elderly people living in their own homes or apartments lack the motivation or means to prepare nourishing meals on a regular basis. However, without a regular and proper diet, many seniors are faced with institutionalization.

If we could find ways to properly fund, expand and co-ordinate voluntary services like the Meals on Wheels Program, we could dramatically reduce our current rate of institutionalization and improve the quality of life of our senior citizens.

Another program within the voluntary sector that performs vital services for our senior citizens is the **Handyman Program.** There are a number of excellent volunteer services of this kind.

For example, SAINTS, or "Students Assistance in North Toronto for Seniors", has 200 students helping over 825 senior citizens. Another organization called "CARE-RING" has 11 offices situated in and around Metro Toronto.

Services offered by these groups include shopping, banking, home visits, transportation to and from medical appointments -- as well as chores around the house.

While such services are highly limited in their distribution across Ontario, we believe that they can be critically important service components of our overall support programs for the elderly.

We believe that the role of the voluntary sector must be expanded and that government should provide adequate funding to ensure that voluntary community-based services can provide seniors and their families with real alternatives to institutionalization.

FAMILY SUPPORT SERVICES

Another type of program that is rarely available -- but critically important -- is **Respite Care.**

Respite care is a temporary service that enables families to have their elderly relatives looked after for limited periods -- for the evening, for the weekend, or during the family vacation.

This kind of service can enable an elderly person to have a change of scene while allowing the family to be relieved of their responsibility for a short period of time. We believe that if we are to encourage families to take care of the elderly, then respite care must become more widely available in Ontario.

Elderly Persons Centres also provide important family support services. These centres offer social, recreational and educational programs as well as a variety of home support services.

While the province currently funds 115 such centres, the total grants to EPCs are limited to only about $2 million annually. If our goal is to shift the system toward community-based support services then the Elderly Persons Centres program should be dramatically expanded.

We would urge the government to consider raising the grants to existing EPCs and to add at least another 100 such centres to the program.

Home nursing programs offered by groups like the Victorian Order of Nurses and public health nurses play an important role in assisting families to maintain the elderly in family settings as well. However, as we shift our emphasis toward

maintaining the elderly in their homes, nursing services -- such as those offered by the private sector and by our public health nurses -- will also have to be significantly expanded and properly funded.

ADEQUATE FUNDING

The problems surrounding each of these community support programs revolve around two central issues: co-ordination, and the level of funding.

Volunteer programs -- which offer critically important home support services -- are funded by a formula that provides up to 50 percent of their costs by the province. However, there are significant expenditures associated with managing large volunteer programs because paid full-time program managers are required to recruit, train and organize volunteers if these programs are to be efficiently managed.

In addition, many of these volunteer home support programs tend to develop and flourish only in our large urban centres.

We would therefore suggest that the government significantly enrich the budget for home support services in two ways:

- first, they should move to an 80 percent funding level for all existing volunteer agencies; and

- second, they should provide significant "start-up" grants for those communities that have underdeveloped home support services -- particularly for places like Northern Ontario.

CO-ORDINATION

In addition to the issue of enriched funding is the question of co-ordination. The current system of government and volunteer programs has basically developed on an ad hoc basis.

Even today the elderly and their families must comb through a plethora of various government and volunteer agencies to find the appropriate service for their particular situation. In the confusion, and in the absence of a strong co-ordinated local social and health care service system, many families simply give up and place their parents or grandparents in an institution.

We believe that all of these services should be co-ordinated through local co-ordinating bodies -- such as the **Placement Co-ordinating Agencies** -- that have developed in a number of communities over the past several years.

A province-wide network of Placement Co-ordinating Agencies could provide a local central community focus to all programs for the elderly. We also believe that they would enable seniors, and their families, to have a "one-stop centre" to obtain the appropriate service they require.

Further, Placement Co-ordinating Agencies should:

- plan and co-ordinate all appropriate home support services at the local level;
- provide professional assessment facilities for seniors so that the appropriate service(s) or program(s) can be delivered to the "right" people; and
- that they should provide on-going case-management for seniors so that they obtain appropriate services according to their changing needs and circumstances.

Chapter IV

HOUSING AND EXTENDED CARE

While the challenge must be to shift the system from its current institutional orientation to a more community-based alternative, there is still a great deal that we must do to develop appropriate shelter policies for the aged, and, just as importantly, to renew and reform our existing extended care facilities.

For those elderly persons who find it difficult to remain in their own homes -- even with a vastly improved network of co-ordinated community-based services -- we must develop a variety of creative alternatives to the Nursing Home and the Home for the Aged.

We believe that the ideal is to develop housing alternatives which will foster independence and self-reliance -- as opposed to dependency and illness.

What we will require between now and the year 2001 is a variety of modes of shelter that can accommodate a range of gradual to more dramatic changes in the needs of our senior citizens.

Other jurisdictions have developed **Senior Citizen Co-operative Housing** facilities which offer various supportive services -- such as homemakers, nursing and medical services. In addition, many of these **Clustered Housing Complexes** also have a community centre that provides a wide range of recreational and educational programs for the residents of these mini-communities.

Here in Ontario, the Progressive Conservative Government experimented with a number of apartment-style accommodation projects under the **Elderly Enriched Housing Program.** The six existing pilot projects include such services as housekeeping, social and recreational activities, one or two meals a day -- as well as medical and nursing care.

The Ministry of Housing in Ontario also currently spends about $100 million annually on **Senior Citizen Housing** -- including assisted rental housing for the elderly.

While these programs are still in their embryonic stages, we believe that the government must address the issue of increasing the supply, quality and range of senior citizen accommodation. We believe that they should consider creating multi-service senior citizens projects which should include nursing care, social and educational services, as well as recreational programs.

One such model is the Philadelphia Geriatric Centre. This centre provides both community housing and continued exchange between the young and the elderly.

The Geriatric Centre in Philadelphia purchased semi-detached and single-family houses in the neighbourhood adjacent to the centre and renovated them to accommodate the elderly.

Throughout Ontario there are now a number of empty school buildings in established neighbourhoods. We propose that the government consider a program that would convert old school buildings into senior citizen centres -- perhaps even with a children's day care component so that the generations can mix and learn from each other.

The Ontario Housing Corporation could then purchase existing housing around the school and convert them into senior citizens' housing based on the Philadelphia model.

We believe that creative solutions are also required for our existing network of **Retirement Homes**.

There are currently about 30,000 retirement home beds in Ontario. These homes offer residential care for the elderly -- typically, a shared or private room, three meals a day, laundry and room cleaning services, supervision of medication and 24-hour staffing.

Residents pay anywhere from $600 to $1,500 per month -- with no government assistance.

However, as our population ages, many residents of retirement homes will require more and more care. In fact, over the past ten years many of our existing rest homes have in fact become "light care" nursing homes.

Currently these homes are not regulated. A report prepared last year by the Long Term Residential Care Association stated:

> "The lack of comprehensive provincial policy and legislation for long-term care has impeded the provision of uniform standards of care, the consistent application of regulatory procedures, and appropriate funding... With no mandatory provincial standards and no form of inspection, a minimum guarantee of quality remains a concern."

We believe that the Government of Ontario must rationalize the entire extended care system -- in retirement homes, rest homes, nursing homes and homes for the aged.

In the retirement and rest home sector this will mean that the province will have to introduce new legislation and provide some form of financial assistance to those residents who require a minimum of nursing care.

All of these accommodation alternatives -- co-operative housing, enriched housing, clustered housing, and retirement homes -- are the kinds of programs which the government must develop if we are to provide a "bridge" for those elderly persons who cannot maintain themselves in their own homes but who do not require institutionalization in a nursing home or home for the aged.

THE EXTENDED CARE SYSTEM

Most extended care services in Ontario are currently provided by two institutions: **Nursing Homes** and **Homes for the Aged.**

However, while they provide essentially the same services, they are operated quite differently.

Nursing Homes fall within the jurisdiction of the Ministry of Health and are governed by the Ontario Nursing Home Act. Homes for the Aged are operated under the Ministry of Community and Social Services and are governed by the Homes for the Aged and Rest Homes Act and by the Charitable Institutions Act.

Nursing Homes receive $47.17 per person per day -- 63 percent of which is paid by the extended care program under OHIP, and 37 percent of which is paid by residents through government pensions, pension supplements and other income.

In contrast, the operating expenses of municipal Homes for the Aged are funded almost exclusively by provincial and municipal governments. These charges average $66.32 per day per resident but can reach as high as $80 per day.

Currently the largest sector in the extended care area is privately-owned Nursing Homes which have about 30,000 beds, compared to Homes for the Aged and Charitable Homes which have about 12,000 beds.

While there are legitimate historical reasons why two completely different extended care systems evolved, we believe it is essential that these two separate streams of care be rationalized, improved and expanded to meet the longer-term needs of Ontario's rapidly growing number of "old" elderly.

The Ontario Nursing Home Association has pointed out a number of problems that result from this two-system approach. In their recent brief they stated that:

> **"Originally nursing homes and homes for the aged were designed to serve two separate clienteles -- intermediate and light care patients respectively. The breakdown of this system has put funding pressure on nursing homes in two ways. First, since nursing homes and homes for the aged serve substantially the same clientele, there is an inherent discrimination on funding against nursing homes. Secondly, an increasing demand on nursing homes to service heavy care patients has resulted in per diem funding unsuited to the real needs of residents."**

We believe that by combining the two systems real improvements can be made.

However, as we set out to rationalize the extended care system -- and integrate it into an overall strategic plan for community-based services -- we must also work to ensure that we humanize and improve the system as well.

In their 1982 brief on the extended care system, the Concerned Friends of Ontario Citizens in Care Facilities Inc. said:

> "At present, nursing homes are not homes, but institutions. Sterile, friendless and lacking humanness and warmth, where old people sit and rock, stare at walls for most of the day or are led around by the hand like small children by inadequately enlightened staff who refer to them as 'dear'. Their days are regimented. They are told when to get up, when to lie down, when to eat, when to bathe, and when to go to the bathroom. Many are not even dressed and live their lives in bedclothes and slippers. If they protest at the treatment they are receiving, they are considered 'difficult' and may be restrained or medicated for their ill-conceived attempts to gain their lost dignity. All of this has contributed to nursing homes being seen by the public as inadequate, hopeless places where old people go to die."

While this statement was directed at some Nursing Homes, it could just have easily have been said about some of our Homes for the Aged as well.

The problems in both of these separate systems revolve around: eligibility; quality of care; funding structures; and co-ordination.

ELIGIBILITY

The Nursing Home Act specifies that residents of nursing homes must require a minimum 1.5 hours of personal and nursing care per day. No maximum level is stated in the legislation, however, 2.5 or more hours is considered to be "heavy" care.

The Ministries of Health and Community and Social Services are fully aware that there is a significant breakdown in the existing system and that thousands of people are admitted to extended care facilities who do not require 1.5 hours of nursing care.

A joint study by the two ministries found that 50 percent of all residents required less than 1.5 hours of care and that at least 12,000 beds were being occupied by people who were not appropriately placed.

On the other hand, many residents of Nursing Homes and Homes for the Aged require more then 2.5 hours of care, that is, "heavy" care. But Nursing Homes are not currently mandated -- or compensated -- to provide more than 2.5 hours of care per day to any patient.

During the past ten years the demographic profile of the residents of Nursing Homes and Homes for the Aged has changed significantly. Today the average age of residents is about 84 years -- compared to 81 years just a decade ago -- and between now and 2001 we expect the number of "old" elderly (85 years old) to increase by about 140 percent.

Therefore, even with major new investments in community-based alternatives, we will still require more and better facilities for extended care.

However, even the existing un-coordinated system cannot be maintained without significant change and improvements to eligibility and access.

We would suggest that the proposed local Placement Co-ordination Agencies -- linked to the entire continuum of care services -- should serve as the agency that provides assessment and appropriate placement within the system.

Such agencies could also provide regular re-assessment of patients in Nursing Homes and Homes for the Aged to determine placement -- and compensation -- for those residents that eventually require "heavy" care.

QUALITY OF CARE

Regardless of "who gets in", the most urgent issue facing the Government of Ontario is the issue of **quality of care** in extended care facilities.

The 1974 U.S. Senate Report on American Nursing Homes found that in comparison to those people with similar disabilities living in the community, nursing home residents in the U.S. demonstrated "a markedly impaired level of overall judgement, reduced capacity for independent thought and action, depressive mood, and low self-esteem".

In their brief the Concerned Friends commented that:

> "We witness residents who deteriorate upon entering a nursing home, who live lives of boredom and loneliness in monotonous isolation with nothing to do and nothing to anticipate... Many residents begin to will their own death, refuse food or engage in self-abusive behaviour or become abusive to others."

We believe it is essential to concentrate our efforts on improving the quality of care in homes. But to obtain higher levels of quality care many new services and programs need to be introduced into our existing extended care facilities. For example, vastly expanded recreational programs, education programs, and library services are required to provide intellectual stimulation for residents.

We need expanded health services -- such as those provided by physiotherapists, chiropodists, speech pathologists, and occupational therapists. We also need professional counselling services, social workers and a vigorous volunteer program to ensure that residents in such facilities maintain healthy human contact and healthy attitudes.

Of course, most of these services will require additional funding. But more money must be found.

The Ontario Nursing Home Association has pointed out that average government funding for one person for one year in a provincial detention centre was $32,850 -- compared to $17,105 in a municipally operated Home for the Aged, and $9,903 in a private Nursing Home.

We believe that funding must be increased to provide higher quality care for the residents of these facilities.

FUNDING STRUCTURE

In our view the core of the problem in the extended care system lies in the basic funding structure.

Currently Nursing Homes receive $47.17 per day per patient and Homes for the Aged average about $66.32 per day for each resident.

While this system has served us relatively well in the past, we believe that government must now re-evaluate what it wants, what it is paying for and what it should do.

Governments must play an important role in both setting agendas for a Seniors policy, and in ensuring that the public is well served by each component of that system.

Delivery systems must find new and innovative ways to restrain the growth of cost increases, while meeting operating needs.

The private sector can have an important role to play in this regard.

The Government needs to examine the operational and financing structure of our institutions and seek out both the institutional framework for financing and operations that enhance rather than weaken this capacity to serve.

An alternative that should be given serious consideration is the assistance and expertise that can be offered by the private sector. This private sector can consolidate expenditures for institutional management and ownership that takes into account the resources, manpower and capital for both the replenishment and construction of facilities and equipment.

Such an approach would demonstrate to the public that governments can obtain value for the money committed by private investment to provide services for seniors.

Ultimately, regardless of what options are pursued, we believe that one role should never be abandoned by government - the vigilant enforcement of standards which preserve the quality of care, the integrity of the system and the prompt and sensitive response to the needs of Ontario's elderly.

We believe that there are creative ways to re-orient the existing extended care system -- provided that we first make significant new public investments in community-based home care services.

Other jurisdictions have already devised mechanisms to accomplish this objective. For instance, there is a unique extended care funding structure currently in place in Israel.

In that country -- which has a mix of both public and private nursing homes -- the per diem rates are structured in such a way that the primary emphasis is on activation and rehabilitation programs.

The Israelis have developed a per diem funding structure that is heavily loaded in the initial admittance period and then declines gradually over time. The economic incentive for nursing home operators is therefore to provide rapid rehabilitation so that patients can be released early and placed back in their communities where they then receive home care services.

In contrast, our existing structure allows for a constant rate; as a result, there is no encouragement to return patients to the community when their circumstances and desire permits. Indeed, our basic methods of funding may inadvertently encourage - and reward - warehousing.

We believe that if we develop a comprehensive and co-ordinated home care system then we can encourage and reward Nursing Homes and Homes for the Aged to concentrate their efforts on rehabilitation.

The government should consider developing a mechanism which encourages operators to regularly evaluate the rehabilitative potential of each patient. Such evaluation would consider the medical, psychological and personal needs and interests should be developed through consultation with medical professions, operators and citizens to ensure that it is both sensitive and feasible. Whatever mechanism is ultimately adopted should reflect a strong commitment to rehabilitating the elderly for return to the community whenever possible.

However, not everyone will be returned to society. That is a fact of life.

In fact, as we develop more comprehensive community-based services and a network of supportive senior citizen housing, Nursing Homes and Homes for the Aged will increasingly find that in the future, a large percentage of their patients will require "heavier" care.

We believe that these operators should be compensated for heavier care cases. We also believe that our homes should work with the local Placement Co-ordinating Agencies to periodically assess the needs of residents and to determine the level of care required and the appropriate facility for them.

ONE-STOP EXTENDED CARE SERVICE

The final issue that must be addressed is the **co-ordination** of extended care services.

We believe that the existing extended care programs operated by the Ministries of Health and Community and Social Services must be rationalized into a single program that is co-ordinated and linked to both the community-based services and to our proposed expanded senior citizens housing programs.

Ultimately Homes for the Aged and Nursing Homes must be funded on the same basis and be subject to the same regulations and inspections. In addition, we believe that Retirement Homes, Rest Homes and Supportive Senior Citizens' Housing must also be co-ordinated and subject to complimentary levels of service and regulations.

Our suggestion is that all services for the elderly be co-ordinated at the local level by a network of Placement Co-ordination Agencies that assess, place and co-ordinate extended care and community-based services. We also suggest that a new Extended Care Services Act be introduced to regulate and fund the Nursing Homes and Homes for the Aged.

It is only with a co-ordinated approach that we, as a society, will ever be able to meet the demographic challenges of the future.

Chapter V

IMPROVING CARE FOR THE ELDERLY

As we examine the basic issues surrounding care for the elderly, the resolutions to the problems appear, on the surface at least, to be relatively simple: better co-ordination; adequate funding; better long-term planning; a rationalization of services; and an increased emphasis on community-based services.

As policy goals, these are easy to articulate but difficult to transform into reality.

However, cognizant as we are of the challenges of changing a system of care -- a good basic system of care -- we must be determined to alter certain existing patterns and to develop whole new approaches to care for the elderly.

This task must, by necessity, involve a "vision" of what is possible -- and a determination to make it happen.

But if we are ever to succeed at changing our basic system of care, we must begin to adopt some longer-term strategies on how to accomplish that goal.

We believe that if we are to fundamentally alter our system of care for the elderly, then we must concentrate on a number of basic systemic issues.

We must alter our approach to the study of medicine; the role of geriatrics within the discipline of the medical and nursing professions; the access and service offered to senior citizens within our medical care system; the role of health promotion; and issues like drug utilization among the elderly.

GERIATRIC MEDICINE

Among the first longer-term issues that must be dealt with is the role and scope of geriatric medicine within the health care system.

Despite the demographic reality that the real challenge facing the Ontario health care system is the care for our elderly, the fact is that medical professionals often do not have up-to-date knowledge on how to deal with complex chronic pathologies.

In the past we trained our medical professionals to be oriented toward high technology "cures" and toward acute care surgical interventions. But since "aging" cannot be cured, our health professionals are often under-equipped to deal with many of the basic chronic ailments of the elderly.

Very few of Ontario's 17,000 physicians have any formal training in geriatrics and even now our medical schools still do not devote much time to clinical geriatric training. In fact, even though the number of geriatric residency posts in Ontario Medical Schools was increased to 19, only 13 of these posts are currently being used to train specialists in geriatrics.

We believe that the Ontario Government should introduce economic incentives for our medical schools to ensure that geriatric training is provided.

Further, because the number of senior citizens will grow dramatically in the next ten years, we would urge the government to establish a Department of Geriatrics at one of the provincial medical schools. This department should not only train future geriatric physicians, but could also be involved in re-training and upgrading all physicians in their knowledge of geriatrics. Special incentives could also be introduced to encourage physicians to learn the newly developed skills and techniques for treating elderly persons.

In addition, the government should ensure that more nurses and nurse practitioners are trained to specialize in geriatrics since this profession has the best skills and orientation to deal with elderly patients.

SENIORS' ACCESS TO HEALTH CARE

On the question of access to the health care system, the Progressive Conservative Party has stated that we are in favour of banning extra-billing to all persons over age 65.

We believe it is critically important that the elderly -- as well as those people on fixed incomes, social assistance or premium assistance -- receive medical care without regard for ability to pay.

However, access to care for senior citizens can also often be a matter of mobility. In a brief to the Ontario Cabinet, the United Senior Citizens of Ontario pointed out that:

> **"It is sometimes very difficult for the frail elderly to make visits to the doctor's office. The United Senior Citizens of Ontario request that doctors visit the frail elderly in their homes in cases of accidents and/or emergencies."**

We believe that the point made by the USCO is valid. We would suggest that the Ontario Ministry of Health negotiate with the OMA mechanisms to ensure that the elderly receive house calls -- when appropriate. Perhaps a special incentive system which compensates physicians more adequately for house calls can be introduced.

HEALTH PROMOTION FOR THE ELDERLY

The most important innovation that we can introduce into our health care system is a whole new orientation towards **health promotion and illness prevention.**

While such activities can revolve around the promotion of good nutrition and exercise they can also relate to the expansion of various "non-medical" services and to changes to provincial drug programs.

For example, the United Senior Citizens of Ontario have pointed out that a large portion of senior citizens use chiropractic care. In fact over 18 percent of chiropractic patients are over 65 years of age even though they are currently only 10 percent of the population.

The United Senior Citizens of Ontario have pointed out that the reasons why the elderly use chiropractic care more frequently than younger patients are that:

- chiropractic care involves conservative therapies which are frequently more appropriate for senior citizens than surgery or drug therapy;

- it pays particular attention to effective management of chronic and degenerative problems -- enabling senior citizens to be active and pain-free in circumstances where complete cure is impossible; and

- it emphasizes lifestyle, posture, exercise, lifting techniques, and other matters of practical value to seniors.

While much of this makes sense, Ontario does not have special rates that enable or encourages seniors to obtain chiropractic assistance when they need it. The maximum amount payable by OHIP is $190.00 per patient -- including $ 35.00 for x-rays -- over any twelve-month period.

The same arguments made by the United Senior Citizens of Ontario about chiropractors apply equally to physiotherapists, chiropodists, speech pathologists, audiologists, occupational therapists and others within the health care system.

Our Task Force believes that as the population grows older, the various health services listed above, including chiropractic treatment and others within the system, can be of substantial benefit to our senior citizens. We therefore suggest that special rates for seniors be developed and negotiated with representative health care associations.

No doubt there are other health disciplines where special rates for seniors would encourage health promotion and our Task Force would be most interested to hear of these from interested parties.

Finally, on the issue of health promotion, we would recommend that the government also consider establishing Community Health Clinics and Health Service Organizations that specialize in caring for the elderly. These "Wellness Centres" could concentrate their efforts on all aspects of health promotion and illness prevention.

DRUG UTILIZATION BY THE ELDERLY

Perhaps the major area where we can prevent illness in our senior citizen population is in the area of drug use.

In 1975 our Party expanded the Ontario Drug Benefit Program to include persons over 65 years of age. Since then, the average drug utilization under ODB has increased from 17 to 25 claims per beneficiary per year and the cost of the program has increased from $54 million to over $244 million -- an increase of about 345 percent.

Our concern, however, is not an economic one.

There are serious indications that many of our seniors are over-drugged and that serious health concerns arise over the utilization of the ODB plan. As much as 10 to 15 percent of all seniors admitted to hospitals are admitted because of drug-related problems.

We believe that the ODB program must be reviewed by the Ministry of Health, the Ontario Pharmacists Association, the Ontario Pharmaceutical Association and the Ontario Medical Association from a purely health-risk perspective.

We acknowledge that this may be a difficult political issue for the government -- if such a review recommends tightening the benefits -- but we believe that our first and foremost concern must be the health and welfare of our senior citizens.

Chapter VI

SUMMARY AND RECOMMENDATIONS

This discussion paper is intended to stimulate debate among senior citizens, their families, care providers, the general public and legislators.

We want input from various groups as we refine and develop our policies concerning our senior citizens.

What we have done in this document is set out a framework for discussion on our future policies regarding senior citizens.

Over the past two decades Ontarians have developed and put in place one of the finest systems of care in the world. But, like all large complex systems, our network of services and facilities must adapt to the changing needs and circumstances of our population.

We have pointed out that the demographic realities of our society are that we will have a 55 percent increase in our senior citizen population between now and the year 2001.

We have further pointed out that while the absolute number of senior citizens will increase by over half a million over the next 14 years, the real impact of a progressively aging population will come from the 68 percent increase in the number of people between 75-84 years of age and in the 138 percent increase in the number of people over 85 years of age.

We have argued that our society is at the crossroads of decision-making. If we maintain our current rate of institutionalization of the elderly -- at 9.45 percent -- then we must spend approximately $6 billion between now and 2001 on both capital and operating costs to expand the institutional sector.

In examining our current institutional system we have pointed out that $475 million is currently being "wasted" in the acute care system because of inappropriate placement and the lack of community-based alternatives.

We have pointed out that a further $160 million is "misallocated" because of blockage in our chronic care system and that a further $220 million is being unnecessarily spent in our extended system due to a lack of community support alternatives.

While the system of institutional care has served our society well over the past two decades, we have argued that future growth must occur in the community-based sector which currently accounts for only about $85 million in expenditures.

We have suggested that in order to correct this tremendous imbalance we must expand, improve and rationalize a whole variety of community-based services: the acute/chronic home care program; the homemakers and nurses services program; meals on wheels; handyman programs; respite care; and elderly persons centres.

We have stated that we believe voluntary agencies involved in programs like meals on wheels and handyman services should be encouraged to expand and flourish. Specifically, we have suggested that:

- we should move from the current 50 percent level of funding for volunteer agencies to 80 percent, and

- we should provide sufficient "start-up" grants for those communities that have underdeveloped home support programs.

We have suggested that all of these programs should be co-ordinated through <u>local</u> Placement Co-ordinating Agencies that would:

- plan and co-ordinate all home support services;

- provide professional assessment; and

- provide case-management and placement services for seniors in a more integrated system of institutional and community-based care.

We have stated that we believe there is a critical need to expand and improve upon a variety of senior citizen housing alternatives so that we develop a "bridge" between institutions and home care programs. These would include: Senior Citizen Co-operative Housing; Elderly Enriched Housing; and Senior Citizen Housing.

We have suggested that Retirement Homes and Rest Homes need to be regulated and funded as "light" care nursing homes.

One of our key recommendations involves rationalizing the existing system of extended care beds. This would mean that Nursing Homes and Homes for the Aged would be subject to the same funding, regulations and inspections and that all of these issues should be addressed in a new Extended Care Services Act.

We have proposed an innovative approach to the funding structure of extended care beds in Nursing Homes and Homes for the Aged which would reward operators for rehabilitating residents and returning them to the community where they would receive home care services.

We have also suggested that extended care facilities be rewarded for taking on heavier care patients.

In terms of the longer-term redevelopment of the system we have made a number of suggestions. Specifically, we have recommended:

- that the provincial government make immediate new investments in geriatric medicine to train practising physicians;

- that the provincial government establish a Department of Geriatrics at one of the medical schools;

- that the government ban extra-billing for seniors and encourage physicians to make house calls on the frail elderly;

- that an increased emphasis be placed on health promotion for seniors;

- that chiropractic benefits for seniors be expanded;

- that we encourage seniors to use the services of physiotherapists, chiropodists, speech pathologists, audiologists, occupational therapists and other health professionals; and

- that the Ontario Drug Benefit Program be examined from a health-risk perspective.

The **Grossman Task Force on Human and Social Services** believes that we have only touched the surface on issues affecting the care of our elderly. We are issuing this discussion paper in the hope that it will stimulate debate and response from seniors, care providers and the general public.

Care for the elderly.